Patient Registration

Today's Date _____/_____/_____ Primary Care Physician______________________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age

Street Address	City	State	ZIP	Social Security (last 4) xxx-xx-	Phone No. ( )

P.O. Box	City	State	ZIP Code

Email Address	

How did you hear of our office (Please check one box): ❑ Dr. ________________ ❑ Website ❑ Social Media

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ________________

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other:

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Primary Phone No.	Alt. Phone No.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize AW Plastic Surgery or insurance company to release any information required to process my claims.

X

PATIENT/GUARDIAN SIGNATURE DATE

CONTACT CONSENT

May we contact you and confirm appointments via e-mail and text (circle one): yes no

Patient History

PATIENT NAME: ____ **DOB:** ____________

REASON FOR TODAY'S VISIT: ______________________________________ **HEIGHT:** __________

ALLERGIES: ☐ None ____**WEIGHT:** _________

CURRENT MEDICATIONS

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

SURGICAL HISTORY (surgery, date)

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

MEDICAL HISTORY

Have you ever or do you currently have any of the following conditions? Check all that apply

☐ Diabetes
☐ Hypertension
☐ Seizures
☐ Problems with Anesthesia
☐ Asthma
☐ COPD
☐ Chronic Lung Disease
☐ Heart Attack
☐ Atrial Fibrillation

☐ Pacemaker/Defibrillator
☐ Blood Clots
☐ Stroke
☐ Bleeding Disorder
☐ Depression
☐ Anxiety
☐ Skin Cancer
☐ Breast Cancer
☐ Anemia

Additional Information:

☐ Other (please describe): ____

Have you ever taken Accutane for acne? ☐ No ☐ Yes – I completed or will complete treatment ___/___ (mm/yy)

FEMALE PATIENTS

# of pregnancies _______ # of children__________

Could you be pregnant now? ☐ No ☐ Yes Are you currently trying to conceive? ☐ No ☐ Yes

Have you breastfed? ☐ No ☐ Yes

Have you had a mammogram? ☐ No ☐ Yes –___/___ (mm/yy of most recent)

Do you have a family history of breast cancer? ☐ No ☐ Yes - ________________________ (relative)

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes ☐ Quit ___/___ (mm/yy)
☐ Nicotine ____(packs per day)
☐ Marijuana

Do you use any illicit drugs? ☐ No ☐ Yes____________________

Do you drink alcohol? ☐ No ☐ Yes____ (drinks/wk.)

Do you exercise? ☐ No ☐ Yes- please describe current activity level _______________________________________

What is your occupation and employer? ____

OFFICE USE Reviewed By: ____ Date: ______________

Protected Health Information Release

Patient Name: ______________________________________ Date: ____________________

1. Concerning matters of my health, **I give permission** for Dr. Wilson or a member of his staff to speak with:

Name of person(s) ___________________________relationship to patient ________________________

Name of person(s) ___________________________relationship to patient ________________________

Name of person(s) ___________________________relationship to patient ________________________

Name of person(s) ___________________________relationship to patient ________________________

2. I request that use and disclosure of the above described information be **restricted** in the following manner [description of restriction]:

____

____

3. I request that my protected health information **not** be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

____

____

Patient Signature: ____ Date____________________

Witness: ____

Financial Policy and Signature on File

- We accept: Cash, Checks (up to $500), Visa, MasterCard, Discover, American Express or Care Credit
- If you are having surgery, your account must be paid in full <u>two weeks prior to</u> the date of your surgery.

<u>Personal Checks:</u>

- There will be a $30.00 charge for all returned checks.
- If you plan to pay for services with a personal check, please be aware that any charges that exceed $500 must be paid by Cash, Visa, MasterCard, Discover, American Express or Care Credit. If you have any questions, please discuss this with a member of our staff <u>prior to</u> receiving services.

<u>Cosmetic Consultation Fees:</u>

- Consultation fees ($250.00) are due at the time you book your appointment.
- Consultation fees are applied towards the surgery cost, only if a $500 NON-REFUNDABLE scheduling deposit is paid within 90 days after your consultation appointment.
- Consultation fees can be applied to treatments that were discussed at the time of the consult for up to 90 days.

<u>Insurance Consultation Fees:</u>

- Insurance consultation fees are at times higher than the standard cosmetic consultation fee. The fees vary depending on the issue of concern and type of consultation. Fees also vary between insurance carriers and individual insurance plans.

<u>No-Show & Cancellation Policy:</u>

- Please allow 24 hours notice when cancelling or rescheduling your appointment with any providers excluding Dr. Wilson. If a cancellation is made less than 24 hours in advance or the appointment is a "no-show", a $100 consultation fee is required to rebook your appointment.
- Please allow 2 weeks notice when cancelling or rescheduling an appointment with Dr. Wilson. If a cancellation is made less than 2 weeks in advance or the appointment is a "no-show" your consultation is non-refundable.

I have read and understand this financial policy and certify that all the information I have provided is correct. I authorize AW Plastic Surgery to bill my insurance company in the event that non-cosmetic services are rendered and I agree I am solely responsible for payment in full to AW Plastic Surgery.

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Anthony J Wilson, MD PLLC DBA AW Plastic Surgery.

I understand that I am financially responsible for all services rendered and for the following reasons:
If: 1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company
(This applies to present and future visits).

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Patient or Responsible Party Signature:____ Date:______________

HIPAA COMPLIANCE STATEMENT

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At AW Plastic Surgery, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit our offices, we record your symptoms, physical examination (including photographs), test results, diagnosis, and treatment. This information enables us to: plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

YOUR RIGHTS

Although your chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information.

OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES

We may leave a message at your home, cell phone, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

Full Name: ____

Signature:____ Date:______________________________

Photography & Video Consent

I, ____
First name Last name Date of Birth

consent to medical images and / or video being made of me, my child or dependent. I agree that duplicates may be made for the referring doctor. The photographs will be taken by one of the members of the AW Plastic Surgery medical staff and will be placed in my medical record for future treatment. I hereby give my consent for AW Plastic Surgery, to use the photographs under the following circumstances.

I agree that the images and/or videos may be: (Please check box below to show consent)

	YES	**NO**
Electronically emailed to my treating health professional	☐	☐
Sent to insurance company for authorization and billing purposes	☐	☐
Used by health professionals for education and training	☐	☐
Used in paper or electronic health publications	☐	☐
Used in marketing materials, including our website and/or social media accounts	☐	☐

By signing below, I confirm that I understand this consent form.

____ _____________________
Signature of Patient/Parent or Guardian Date

____ _____________________
Signature of Doctor/Health Professional/Staff Date